

The Mental Health Conditions of Cambodian Refugee Children and Adolescents

A Senior Honors Thesis

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Introduction

The dire mental health situation of Cambodian refugees in the United States first became apparent to me on my second trip to visit my fiancé's family. I woke up in the middle of the night on the second night of the trip to hear his mother screaming loudly in the room next door. She began banging on the wall and I could hear her breathing laboriously through the thin wall. I ran towards her room thinking she was hurt, having a heart attack, or something worse. My fiancé stopped me and whispered that she was "just" having a nightmare about Cambodia. He told me how she had been having these nightmares for as long as he could remember. He stated that they used to make him cry when he was a child but he thought it was "normal" now.

Over the course of our five-year relationship, I have noticed other responses and occurrences among his family members that are quite concerning. His maternal grandma had constant headaches. Two of his cousins have tried to commit suicide. One of his paternal aunts will never leave her room and is extremely depressed. One of my fiancé's uncles deals with frequent forgetfulness. His paternal grandpa's death was tied to his alcoholism. He constantly drank so that he did not have to remember what happened to him and his family in Cambodia decades ago. Most of my fiancé's family deal with extreme anger issues and their shouting matches leave the children sobbing and shaking. These are only the things that I have personally seen and experienced. Other things I will never see, such as the abuse that results from the anger, depression, and cultural differences between parents and children in my fiancé's family. I know my fiancé was beaten horrifically as a child which has left him with scars both physically and emotionally.

I began to realize how all of these issues and symptoms seemed to be heavily

concentrated in his family. It just did not seem “normal.” So after some brief research I realized that it wasn’t just my fiancé’s family but thousands of Cambodian families reporting similar ordeals. These tribulations were the symptoms and results of Post Traumatic Stress Disorder, Depression and a host of other emotional issues.

Cambodian refugee families were still being affected by their experiences in Southeast Asia from decades before. What I had learned scared me. I could not fathom how my fiancé had turned out relatively normal. But the closer I became to my now fiancé the more I realized that he had been affected, quite traumatically.

I wanted to learn more so that I could better understand what he and his family had been through and were still so affected by. I needed to understand how young Cambodian refugees, like my fiancé, who did not remember their birth country, were still reporting similar symptoms and mental health issues as their elders who had experienced every aspect of the Cambodian trauma. I wanted to be aware of what type of effect caregivers and parents were having on their children. So, I decided to complete an honors thesis on this topic so pertinent to my life so that I could answer the questions I had. I am getting married to my fiancé in July 2007 and from that time on I will be part of his family, just as he will be a part of mine. I owe it to my future Cambodian family to understand what they are experiencing.

Upon completing an extensive literature review on the mental health concerns among Cambodian refugees, three main themes arose. First, many Cambodian caregivers were having a negative effect on the mental health of Cambodian children. Second, Post Traumatic Stress Disorder among the children is heavily correlated with traumatic events experienced outside of the United States. Third, Major Depressive

Disorder is related to current stressors and experiences while living in the United States. Before delving into these topics I will discuss the trauma Cambodian children experienced during Khmer Rouge rule in Cambodia, life in the refugee camps and life in the United States. It is important to comprehend the historical background and current reality of this population to adequately analyze their mental health statuses. There will also be a brief explanation and discussion of PTSD and depression as well as a mention of research limitations with this specific population.

Background Information: The Trauma, Mental Illness and the Children

The Cambodian Trauma

Khmer Rouge Occupation

The Communist Party of Kampuchea (the Khmer Rouge) first came into power in April 1975 after winning a civil war that gripped the country from 1970-1975. The Khmer Rouge ruled Cambodia from 1975 until 1979 which is the period in which they instigated massive amounts of trauma and death. The Khmer Rouge were then removed from power in 1979 by North Vietnamese forces. However, this did not eliminate the Khmer Rouge who continued to use guerilla warfare against the Cambodian government until 1999 when they were defeated (Rummel 1994).

Despite the few years the Khmer Rouge were actually in power in Cambodia (1975-1979), they caused an unbelievable amount of starvation, torture, death and mental anguish. During the Khmer Rouge regime, the ranks of the organization were primarily poor rural peasants who were dissatisfied with the social structure of their

country and sought to implement reforms that equalized all Cambodians and eliminated the benefits that wealthy urban elites enjoyed. This massive attempt at societal restructuring was achieved by forcing all of the approximately seven million citizens to live in concentration camps and work collectively to produce basic commodities. This collective work was targeted toward the cultivation of rice. All basic freedoms and rights that were previously enjoyed were erased. All land, animals, and means of production were collectivized. There was no money or a market system. There was no personal food or independent eating. There was no mail, foreign medicines or holidays. Buddhism, the base of Khmer family relationships and society, was lost. It became a crime to practice religious beliefs. The civil, social, and economic structure of Cambodia was eradicated and replaced by the dictates of the Khmer Rouge (Rummel 1994).

Under the Khmer Rouge, the Khmer way of life was decimated. Children were separated from their families and became part of the Khmer Rouge family instead. Children were forced to live in children's barracks and sent away to worksites far from their families. Sarah P. Tun was four years old in 1975 when she was separated from her mother and yet she still recalls the experience

My sister and I were put into an orphan's home . . . We each had only one skirt and one blouse. We lived on the second floor. We were afraid of ghosts because there were so many dead people around the village. We were so skinny. We never had enough to eat. Sometimes we ate raw grain. We stayed at the orphan's home for about two years without seeing our family (Pran 1997 pg. 84).

The Khmer Rouge believed that the influence of family threatened the strength of their regime. 'Familyism' (*kruosaa niyum*), or missing one's family became a crime that could be punished by death (Pran 1997). Besides losing their families, children also lost

their childhood. There was no formal education or leisure time and children were expected to perform arduous physical labor. There was inadequate health care, food provisions and shelter. Cambodian children became slaves, working for the Khmer Rouge.

Gen Lee was a young girl when the Khmer Rouge came into power. She still remembers the hard work that she did for the Khmer Rouge and the poor rations she received for her labors

My [female youth work] unit transplanted and replanted rice and harvested the grains. There were times as I would smack a handful of rice plants against the side of my foot that I would fall forward into the thick brown water. My body was light, and I was unable to balance myself against the heavy mud [in the rice fields]. We were forced to build dams and trenches. Every day we overworked our malnourished bodies. My unit was always on the move, working on different projects that were usually never completed...rations of food were meager...the usual ration was no more than a bowl of water with a few grains of rice. But this was better than nothing. It tasted like fine cuisine! It was difficult to work more than ten hours a day on an empty stomach... (Pran 1997 p.106).

No one knows exactly how many people died under Khmer Rouge rule. The Khmer Rouge did not keep records of the numbers that died and simply threw victims into mass grave sites to be forgotten forever. Estimates are that anywhere between 1.7 million and 2.5 million died between 1975 and 1979 of a starting population of seven million (Rummel 1994). These deaths were the result of starvation, disease, and in some cases, torture. Many survivors have been traumatized by the torture they saw and experienced. Sarom Prak was a young teenager during this time and remembers the many forms of torture he witnessed

The Khmer Rouge killed teenagers. They held their arms up, disemboweled them, and cut out their livers and gall bladder and put them into sacks. Some of the Khmer Rouge soldiers ate the livers of their victims. The young boys moaned and shouted out in pain. They disfigured their bodies and slashed the throats of young children and babies. The Khmer Rouge tore the babies into

pieces. Some people, who accidentally broke their knives, hoes, axes, and plows they were working with, were slaughtered by the Khmer Rouge... (Pran 1997 pg. 70).

Times of Transition

Upon the fall of the Khmer Rouge regime in 1979, the country was in upheaval. Vietnamese forces began moving across the country, fighting and killing Khmer Rouge along the way. Many innocent citizens got caught in the crossfire. Individuals began to return to their home villages in hopes of being reunited with their families. Others made the journey to Thailand in order to receive the security, medical care, and provisions promised by the UN-supported refugee camps that began to appear overnight along the border. This journey could take a month or more as people had to be mindful of landmines and soldiers who would try to kill or steal from the refugees. Gen Lee made this journey at nine years old. Her family was forced to leave because of poor harvests in their native village and the unending fighting between the Khmer Rouge and Vietnamese. She recalls their attempts at escape

We had to cross the border three times. On the first attempt we were robbed by bandits and abandoned in the forest. My family then walked into a temporary refugee camp on the Thai border. But less than two months later we were forced to return to Cambodia through the Dangrek Mountains, where there were lots of land mines and corpses. After about two months of walking barefoot in the summer heat with little food, we finally reached the place for which we originally had started, an area on the border where we could quickly cross into Thailand again. An honest man safely guided my family to an old refugee camp in Thailand where we stayed for two days before being sent to another camp... (Pran 1997 108-109).

Approximately 34,000 Cambodians were able to escape from the Khmer Rouge between 1975-1979. The number of individuals who were unable to escape until after the fall of the regime were significantly more numerous. In 1979, 137,894 people were living in a United Nations High Commissioner for Refugees (UNHCR) camp. In 1980,

an additional 43,608 were admitted. These figures do not account for the thousands of Cambodians living in border camps that sprang up around the official refugee camps supported by UNHCR. In 1982, figures for the number of people living in border camps first became available. It was estimated that the cumulative number of Cambodians living in border camps in 1982 was 215,000. This number continued to increase exponentially as the UNHCR refugee camps stopped admitting people. Those that didn't arrive directly after the fall of the Khmer Rouge were not considered refugees by foreign governments and thus were not eligible to live in the UNHCR camps. Instead, they were forced into border camps (Chan 2004).

Living conditions in either the UNHCR or border camps were highly dependent on luck. Overall, UNHCR camps were characterized by better medical facilities, living conditions, and improved food rations since these camps received the most funding from foreign governments. For example, Khao I Dang was one of the nicest camps, characterized by two hospitals, a water supply system, adult education classes, and dozens of volunteer medical teams. In fact there was a ratio of one doctor to each 1,500 refugees, which is exceptionally high. In comparison, Sa Kaeo could barely be called a camp. It was one of the first camps to be built by the UNHCR and its downfall helped the UNHCR learn ways to improve future camps. Sa Kaeo was built on a rice paddy which meant that drainage was poor and posed a major health hazard. Blue plastic sheets were used to make "houses" which was a poor source of shelter when it rained. People would lay in inches of mud and many died after suffocating in the mud when they became too weak to hold their heads up. Needless to say, Sa Kaeo did not enjoy the education classes or hospital facilities of Khao I Dang. Rosalynn Carter, the

First Lady of the United States at the time, visited Sa Kaeo in November of 1979. She was dismayed by what she saw, “We discovered a virtual sea of humanity... they were lying on the ground, on mats or dirty blankets or rags. All were ill and in various stages of starvation; some, all bones and no flesh; and others with crackled feet and swollen as though to burst. All with serious diseases, such as malaria, dysentery, and tuberculosis. All retching, feverish, and silent...Seeing the children was the most difficult part of all (Chan 2004 p. 49).”

Given the insurmountable despair of life under the Khmer Rouge, treacherous escape from Cambodia, and difficult life in the refugee camps, it is not surprising that the adults, adolescents and children that survived were affected psychologically by their experiences. As we will learn in subsequent sections, mental illnesses are related to the number of traumatic experiences an individual has faced. One 1984 study of children and adolescents recently arrived in the United States found that 46% had been separated from their parents for more than two years, 60% were beaten or saw their relatives beaten by Khmer Rouge soldiers, 63% lost a parent or saw them killed, 83% suffered from extreme malnourishment, and 38% were threatened with death (Kinzie, Boehnlein, & Sack 1998). These statistics certainly illustrate the trauma and anguish young Cambodians had to face. Hong Chork (who was six when the Khmer Rouge first came into power) survived this trauma and now lives in Washington, D.C. Despite being a survivor, he will never be the same as he was before, “My childhood was lost during those years. I will never be able to recapture this time. I will never be able to feel the peace that I did before I turned six. I will never be able to see my dead brothers and sister again (Pran 1997 pg. 127).”

Living in the United States

For many young Cambodians life did not get easier upon arriving in the United States. They may not have had to deal with the torture and starvation that characterized their memories of Cambodia under Pol Pot, but the sense of uncertainty remained. Cambodian families had to adjust to a new culture and way of life in the United States. Many youth received formal education for the first time, since this was not allowed under the Khmer Rouge. They had to make up for the years of learning that they had lost and adjust to being a foreigner in a strange country. These individuals also had to learn a new language and customs.

Life has not been easy for subsequent generations of Cambodians either. While today's Cambodian youth may be familiar with customs in this country and even the language, they are still dealing with their own difficulties growing up in the United States. Cambodians today are still impoverished, poorly educated, and dealing with complex trauma and mental health issues. According to the 2000 Census, there are 206,052 individuals in the United States who have Cambodian ancestry. 34.2% of this figure were born in the United States. An additional 30% are foreign-born naturalized citizens. The states with the largest populations of Cambodians are California (84,559 people), Massachusetts (22,886) and Washington State (16,630). Over 70% of Cambodian households have someone under 18 living within the household (Southeast Asian American Statistical Profile 2004). This indicates that the majority of Cambodian households include traumatized adults impacting the lives of Cambodian youth.

Even today 53.5% of the Cambodian population speaks English less than very well. Over 90% speak Khmer and not English at home. Not having English language

skills can be a barrier to obtaining jobs and be a hindrance to education. Speaking of education, 47% of Cambodians in the United States have graduated from high school. Less than 10% have earned a minimum of a bachelor's degree. The low educational achievement of this population is a huge barrier to successful performance and acculturation in this country. More and better education is required to obtain higher-paying jobs.

Cambodians are, in fact, not obtaining the better-paying jobs as indicated by median family incomes and poverty rates. Median family income is \$35,621. In comparison, the median family income for the general population is \$50,000. Also, Cambodians have larger families which places an even bigger strain on family income (We the People: Asians in the United States 2004). Nearly 50% of Cambodian households consist of five or more people. Over 29% of Cambodians live in poverty. Per Capita incomes are only \$10,215 among Cambodians. When comparing this to the general population's per capita income of \$14,267 it becomes more apparent the dire financial situation this population is in. In fact, over 22% of Cambodians receive public assistance, while on average less than 10% of the general population does (Southeast Asian Statistical Profile 2004).

As might be inferred by the brief statistical profile of Cambodians provided above, this population is struggling economically and has not fully assimilated or acculturated into this country. It is not due to lack of hard work that this is happening. Sombat is a young Cambodian parent who is a factory worker from Chicago. According to him, "Cambodians had to work very hard under Pol Pot for no money and almost no food. We know how to work, and if there are jobs we can do them. I have a harder job than

any Cambodian I know. My hands look as bad now as they had under the Khmer Rouge (Chan 2004 p. 192).” It is because of low levels of education, lack of job skills and unfamiliarity with the United States that makes economic survival difficult.

This difficult financial situation has greatly affected the children of this population. Poverty has been found to have a negative effect on mental health and high rates of depression are common. The conflicts between generations and different rates of assimilation are affecting the mental health of Cambodian youth as well. For example, Sohko Pich discussed with a teacher the problems her mother had with her choice of clothing,

...To my mother I was dressed like a gangster. It was not that she was worried about my life being in danger. A more important concern was that I was disgracing her and the family because it seemed as though she had not raised me properly. Not only did my image disgrace her, but it also reminded her of the Khmer Rouge. I would not listen to my mother about anything...There was nothing my mother could say that would make me listen...I was at a stage where I thought every adult was against me and I was against their traditional ways. My mother would always complain that just because I went to school here and she didn't doesn't make her stupid. I never listened because I thought I knew everything and I was so cool (Chan 2004 p.214).

Small details, such as clothing choice, become a major point of division between generations and affect the relationship between the caregiver and child.

Sometimes the relationship between generations can become so strained that the child may decide to join a gang. This phenomenon has been increasing in the United States as young Cambodians become stuck between cultures, grow distant from caregivers, and have little educational and economic opportunities. Him Chhim with the Cambodian Association of America in Long Beach describes this phenomenon

Due to the lack of a nurturing home environment, the lack of role models in the home, too many of our children drop out of school and join gangs by the thousands... they don't find comfort, love, or anything interesting for them to do

inside their homes. They live in crowded neighborhoods, crowded apartments, unsanitary conditions, and spill over into the streets. That's where the gangs recruit them... (Chan 2004 p. 219).

As has been indicated by the preceding examples, life for Cambodian youth can be difficult in the United States. It is no easy task to negotiate cultures and succeed in an unfamiliar environment where your parents can offer little advice or support. The mental health consequences these individuals can face will now be discussed in more detail.

Cambodian Children, Adolescents, and Mental Health

Because of the difficult and traumatic experiences Cambodian children and adolescents have experienced, there have been profound mental health ramifications. The most commonly reported psychiatric disorders are Post Traumatic Stress Disorder and Major Depressive Disorder. These mental health issues will now be described generally and discussed briefly.

Post Traumatic Stress Disorder

According to the American Psychiatric Association, PTSD is the result of

Exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death, injury experienced by a family member or other close associate (American Psychiatric Association 1994 p.424).

PTSD is a formally recognized anxiety disorder. A specific combination of symptoms must be realized for someone to be diagnosed. These criteria are spelled out in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*

(*DSM-IV*), which clinicians use to officially diagnose a patient. Some of the criteria that must be met include: symptoms related to re-experiencing the traumatic event, persistent avoidance of stimuli associated with the event, persistent symptoms of increased arousal, symptoms that last more than one month and impairment in various areas of the patient's life and functional ability (American Psychiatric Association 1994). An individual can re-experience a traumatic event when they are both awake and asleep. While awake, a person can become detached from reality and believe they are actually re-experiencing the trauma at the present moment in time. While asleep, many with PTSD can suffer from horrific nightmares of their experiences. The second criterion consists of avoiding anything that may remind them of the trauma. This often leads an individual to become "numb" and detached from their surroundings, family and friends. The third criterion comprises the individual being exceptionally watchful and very anxious. This can result in the inability to concentrate, angry outbursts and difficulty sleeping. Some of the most common symptoms that the Cambodian refugee community has reported are chronic headaches, dizziness, sleep disturbances (for example, nightmares), an exaggerated startle response, chronic pain and poor memory and concentration (Chan 2004).

While officially diagnosing an individual using *DSM-IV* is certainly necessary, it fails to recognize the possible long-lasting biological, behavioral, social, and cultural effects of experiencing traumatic events. For example, some young survivors suffer from developmental delays (or lacunae). This can especially be the case when current development tasks are interrupted due to trauma events, as is the case with Cambodian youth who lived during Pol Pot's rule. In regard to biological effects, many Cambodian

youth survived torture, beatings, and rape which may have impacted their physical health (Kinzie, J. & Jaranson 2001). Social and cultural effects of trauma events will be discussed in detail in a later section. Regardless of what each individual case of PTSD or PTSD symptomology may be, it is imperative that the consequences of trauma events be recognized as “multidimensional and interconnected; no part of the survivor’s life is left untouched (Gerrity, E. et al. 2001 p.8).”

The age of an individual upon exposure to a traumatic event can impact the development of PTSD diagnosis and symptoms. It is true that the younger individuals are, the less likely they are to recall specific trauma events. Many studies have found that older Cambodian children recalled more exposure to trauma than the younger children did (Realmutto et al. 1992). Recalling trauma exposure is a key facet to diagnosing PTSD. Despite this, younger children can also be more affected and distressed by trauma events since they are impressionable and vulnerable. For example, young Cambodian children were extremely distraught by the forced separation from their parents, experiencing the disappearance of their caregivers, and even their deaths. Cambodian adolescents during the Khmer Rouge rule may have less memory of the traumas their families experienced than their elders, but were certainly exposed to grotesque torture and death. Apparently many Cambodian children and adolescents have managed to remember specific trauma events given the high rate of diagnosis in this community. The high rates of PTSD diagnosis (which will be further discussed in subsequent sections) exist despite how young many of these individuals were while living in Southeast Asia (Pynoos J., Kinzie, J. & Gordon, M. 2001).

Cambodian refugees have displayed higher rates of PTSD and depression than

any other Southeast Asian refugee group. The symptoms experienced by Cambodians have persisted longer than other refugees from this region (Chan 2004). When comparing PTSD rates to other traumatized populations, we find similar results. Cambodians, including Cambodian youth, have much higher prevalence rates. On average, studies have found a prevalence rate of 50%-60% for Cambodian adults and 30% for Cambodian children and adolescents (Sack, Clarke & Seeley 1996, Kinzie, Boehnlein & Sack 1998, Marshal et al. 2005). In community samples, where there is not an apparent risk for PTSD, prevalence rates range from 1% to 2.6%. (Davidson et al. 1994, Saigh 1992). Among American combat veterans from the Vietnam War rates of PTSD are 20% (Buydens-Brachey, Noumair, & Branchuy 1990). This brief comparison of PTSD rates illustrates how significantly affected Cambodian refugees are from their experiences.

Major Depressive Disorder

Another common psychiatric disorder that Cambodians have been afflicted with is Major Depression. This mood disorder can cause severe distress and one episode can last on average six to nine months. While this disorder usually first appears when an individual is in their 20s, it has been found to occur at anytime in life, including childhood. In order to be diagnosed an individual must display at least five symptoms. These symptoms include fatigue, sleeplessness, low self-esteem, loss of appetite, loss of interest, low mood, agitation, insomnia, feelings of worthlessness or guilt, and suicidal behavior. A person can be diagnosed as having recurrent major depressive disorder if they have had at least two depressive episodes. These episodes will occur about every four years and evidence has shown that the frequency of episodes will increase with

age. The more depressive episodes experienced, the more likely an individual is to attempt suicide and the more impaired the individual is by the disorder (Morrison 2006).

Longitudinal studies have shown that depression has remained steady at around a 5% prevalence rate in the general population (Taking the Long View of Depression, 2000). Recent studies have shown that among children and adolescents, depression is becoming more common. By the age of 14, 9% of children will experience a major depressive episode. This likelihood increases to 20% by the time a child graduates from high school (School-Based Program Teaches Skills That Stave Off Depression 2003). Among Cambodian children and adolescents rates of depressive disorder for the entire population are not known. Only localized studies have been completed with this population. In one longitudinal study rates of depression for the sample ranged from 48% to 14% at different points in time (Sack, Him, Dickason 1999). These rates are much higher than among children in the general population because of the experiences of trauma and distress Cambodian children have experienced. Also economic instability and difficulties within the Cambodian family are major factors that increase the risk for these children to experience depressive episodes.

Research Limitations

Like many other studies that focus on PTSD and other mental health illnesses, there are important limitations to the research that must be recognized. One main issue that those researching Cambodian youth face is that there is not a readily accessible control group to compare findings with. Relatively few Cambodians lived in the United States prior to the 1980s. In fact, nearly 74% of Cambodians entered this country between 1980-1989. Only 10% entered prior to 1980 (We the People: Asians in the

United States 2004). This leaves very few Cambodians whose families were unaffected by the horrors of the Khmer Rouge to serve as a comparison group.

A second limitation of the data is that most studies are focused on specific Cambodian communities across the United States. This is unavoidable given the fact that most Cambodians reside in ethnic enclaves and are not evenly dispersed throughout this country. This is often a reality in any research that involves refugee and immigrant populations and is not unique to Cambodians. Despite this, the majority of studies completed with Cambodians have large sample sizes, high response rates from subjects, and are done in areas with high proportions of Cambodians residing in the area (Marshall et al. 2005, Kinzie, Boehnlein, & Sack 1998). These are all factors that help to minimize bias. Also, since Cambodians tend to live in ethnic enclaves perhaps it can be considered appropriate to focus on specific communities and not necessarily consider it a negative research limitation.

Another limitation related to PTSD studies with Cambodian refugees is that trauma events are being analyzed retrospectively and so there is a reliance on the self-report of trauma by the subjects. Some studies are essentially relying on the subject to recall events that occurred multiple years ago. However, this retrospective recall of events and symptoms is a reality in many psychiatric studies.

One last essential limitation to conducting research with Cambodian refugees is the propensity for Cambodians, including young Cambodians, to underreport their symptoms. Many subjects may not be truthful and hide symptoms because they do not trust mental health practitioners who are of a different ethnicity than them. They think the clinician will not understand what they are experiencing or may judge them

negatively for their mental health concerns. Underreporting also occurs because Cambodians are socialized by their parents and culture to refrain from sharing their experiences as they are a sign of weakness and disgrace family honor (Chan 2004). There is no way to dissuade these instances of underreporting (Cambodian culture and practices must be respected) except to encourage sincerity and perhaps employ Cambodian mental health workers to conduct interviews to encourage honesty (Sack, Him, & Dickason 1999). Many researchers have chosen to do this already. Despite these limitations, research on the mental health of Cambodian adults, adolescents and children still reveal the poor mental health reality of this refugee population.

The Affect of Caregiver Mental Health on the Children

Mental Health Diagnosis within the Cambodian Refugee Family

Many Cambodian children and adolescents living in the U.S. today did not live in Cambodia during the genocide. Many were born in refugee camps in Thailand and most were born in the United States after their parents sought refuge in this country. It is true that the stress of relocation to the United States and cultural conflict have impacted the mental health of Cambodian refugees. However, PTSD is usually associated with traumatic events prior to migration to the United States in this population. The majority of younger Cambodian refugees have no recollection of the trauma in Cambodia yet they still have significant rates of PTSD diagnosis (Savin et al. 1996, Mollica et al. 1997). How is this possible? For many children, it is the mental health issues of their parents, and perhaps their grandparents and older siblings that

are impacting their mental health.

In the Cambodian refugee family the care of children is shared. Oftentimes, grandparents live with their adult children and help care for their grandchildren while their adult children are at work. Older siblings also take on a large burden in helping care for the young. With all of these individuals living through the genocide concentrated in one house it is very likely that the rates of PTSD within the household are high. In fact, even two decades after the trauma experienced in Cambodia, studies show that 62% of adult refugees still suffer from PTSD and 51% suffer from depression. Characteristics that are common among those with a PTSD diagnosis included poor English-speaking proficiency, poverty, unemployment and those who are older (Marshall et al. 2005). Other studies have also found that women are more likely to receive PTSD and depressive disorder diagnoses. In a study completed in Portland, Oregon, 1/5 of Cambodian adolescents (209 adolescents participated in the study), 1/3 of the fathers and 1/2 of the mothers received a PTSD diagnosis (Sack et al. 1994). Females are more often the caregivers of children in Cambodian culture and spend more time with the children. Their mental health diagnoses will thus impact the relationship and even mental health of the children more than a male living in the same household.

Research has shown a trend for PTSD to cluster in families. In one study the relationship between the mental health of the parent and child was researched. A sample of 209 Khmer adolescents aged 13-25 and their parents were interviewed and completed diagnostic measurements of PTSD. Environmental factors such as socioeconomic status, differences in living arrangements, greater amount of war trauma

and greater amount of reported loss were controlled for. When neither parent had PTSD only 12.9% of the adolescents had PTSD. When only one parent received a PTSD diagnosis the prevalence rate among the youth increased to 23.3%. Lastly, when both parents had PTSD, 41.2% of the youth received a PTSD diagnosis. Major Depressive Disorder (MDD) was not found to occur significantly more often within the same family (Sack et al. 1995b, Kinzie, Boehnlein, & Sack 1998). These findings suggest that PTSD clusters in families, especially when multiple caregivers have a PTSD diagnosis. Unfortunately this study did not go further to discover the relationship between grandparents and other family caregivers and PTSD in the youth.

The Effect of Mental Health on Parenting Skills

Yet another way caregivers are affecting the mental health of Cambodian refugee children is the impact mental illness can have on parenting skills and the ability to be an effective parent. The functional ability of these parents as refugees in the United States is an issue that is pertinent to their ability to parent. Cambodian parents with PTSD or PTSD plus depression are more likely to be receiving public assistance (welfare) and more likely to have lower incomes (Sack et al. 1995a). This illustrates that there are still barriers that are affecting their ability to adjust to life in the United States and sustain themselves and their families. Sack's 1995 study also found that of the 159 parent participants, 60% of the mothers and 39% of the fathers sought treatment for mental health issues (Sack et al. 1995a). This suggests that the mental health symptoms were severe enough to be affecting daily functioning to a degree that made these individuals decide to seek outside help.

Another issue that is inhibiting parenting skills is the language barrier that often

exists between the caregivers and child. It is hard to talk, nurture, discipline or even understand a child's perspective and opinion when you can't understand each other. As highlighted in the previous section, 91.6% of Cambodian households do not speak English at home. Also, 53.5% of Cambodians reported their English speaking ability as less than "very well" (We the People: Asians in the United States 2004). This inability to communicate in English may make discussing abstract and complicated ideas an immense task. For example, many caregivers don't feel able to communicate the horrors of the Cambodian genocide or even life before the genocide to younger generations (Rubin & Rhodes 2005). All of the factors discussed indicate that the functional ability of Cambodian parents may be impaired and perhaps these are also affecting the ability to be an effective parent.

Besides functional ability, caregiver's are also inhibited in raising children because many of them were essentially raised by the Khmer Rouge. While the Khmer Rouge was in power children aged 6 and up were separated from their families and forced to work in the youth work brigades and under the guardianship of the Khmer Rouge. This was done so that they could be "re-programmed" and trained to support the new communist order the Khmer Rouge were undertaking. These children and adolescents were forced to work long hours even if they were ill, exhausted or starving. They were taught to betray their family members and other children and report them for illegal activities. They were denied any formal education besides communist rhetoric. They didn't have any parental figures or permanent caregivers as they were often moved from camp to camp to work on different projects. These young Cambodians had to defend themselves and always be on guard out of fear of being punished by the

Khmer Rouge or accused and betrayed by their peers. This can be exemplified by the following narrative provided by a child who was part of a youth work brigade:

I saw orphans of seven to eight years old...who'd stolen rice, salt, and vegetables because they were so hungry. A cadre caught them by surprise, and he has them beaten until they bled. Another time they stole...the chief tied their hands and feet and put them for two hours in a place infested with tiny ants, until blood was pouring out. Then they were beaten with a can and then put back with the ants...A third time they were so hungry-they were nothing but skin and bones- they stole vegetables from the kitchen. The Khmer Rouge cadre picked eight children to beat them and then bury them alive (Chan 2004 p.23).

This was not a nurturing environment to be raised in. Now these individuals are parents. Even if today's parents of Cambodian adolescents and children weren't separated and raised by the Khmer Rouge their lives were very much interrupted by the war, genocide and life in the Thai refugee camps. These events and the hardships experienced because of them have been detrimental to their development and lives. They haven't had a healthy childhood or experiences from which they learned how to be a parent or learn the skills and attributes necessary to raise children in the United States.

The mental health and life events experienced have affected the function of parents and caregivers within the family. Because of these factors, "numbness, avoidance, and vulnerability to stress often lead parents to be frightened, confused or simply uninvested in the basic care of their children (Kinzie, Boehnlein, & Sack 1998 p. 212)." For example, many Cambodian parents who have sought treatment have appeared to be "numb" or detached from their children which affects the parent-child relationship and the children's growth. There is a lack of warmth and some parents have been found to avoid their children or display withdrawal behavior. This leads to agitation and irritability, according to mental health professionals who have been

treating Cambodian families since the 1980's. It has also been reported that this unhealthy relationship between parents and children sometimes results in domestic violence and child abuse, and also alcohol abuse (Kinzie, Boehnlein, & Sack 1998). For example, one California study found that 25% of reported child abuse cases committed by Cambodian parents were carried out because of the parent's mental illness. The other highest circumstance resulting in maltreatment was the category gambling/alcoholism/substance abuse. 26% of child abuse cases were related to this category (Rhee & Chang 2006).

A recent study completed by scientists at Hiroshima University has further researched the impact a parent can have on a child. The researchers recognized that parent-child relationships and a nurturing environment early in life can affect later mental development and influence prevalence rates of psychiatric disorders, such as PTSD. However, they recognized that most studies (including those done with Khmer refugee families) are conducted retrospectively. This means that determining early trauma is dependent on self-reports which may be unreliable. They wanted to discover if early adversity and trauma can affect the severity and risk of PTSD, without relying on self-reports. After performing a series of tests on young rats which exposed them to a variety of "single prolonged stresses" (such as being forced to complete complicated mazes and placing them on hot plates), they found that if the young rat was isolated from the mother PTSD-like symptoms were worse than those who were not isolated. From their results they determined that early adverse experiences may possibly increase the severity of PTSD symptoms later in life, especially without a nurturing parent or caregiver relationship (Imanaka, A. et al. 2006).

Cultural Conflict and the Parent-Child Relationship

Another life event that has greatly affected the mental health of Cambodian refugee children and their caregivers was the move to the United States. After spending multiple years in refugee camps in Thailand these families, if they were lucky, would finally obtain refugee status and be able to move to the United States. Little did they know that this move might further hinder family relations as children became more Americanized while older generations held on to Cambodian customs and beliefs more effectively.

After moving to the United States, members within the Cambodian family adjusted and acculturated to different degrees. Acculturation is the process of adopting the values, norms and customs of a host country. In one study of Cambodian adolescents living in Montreal, acculturation levels were reported to be as high as 95.8% after living in Canada for 12 years (Rousseau et al. 2004). Cambodian children and adolescents are often more influenced by the culture and society of their host country because of their increased interaction with peers in school and attraction to western value systems that are supported by their western education. This has affected parent-child relationships and also the family environment. Parents are more likely to hold on to traditional Cambodian family values. These family values are deeply influenced by Buddhist thought and include placing elders in roles of authority and great respect. Traditionally the decisions of elders were never questioned. Along with this, it is the child's duty, even in adulthood, to follow the recommendation of their parent and elders. Lastly, family identity is to be at the center of self-worth and personal identity (Kinzie, Boehnlein & Sack et al. 1998). This lack of respect because of differences in

acculturation can be exemplified by the following report a mother gave about her teenage daughter

When I was teenager, I am so respectful to my parents, like when they talk, even good or bad ok. But teenager here... it's not the way I expect them to be. It seem to me like they don't respect me at all... even I teach them how to say good, how to be good, they don't understand at all, they say, What is wrong with this? When I say, you do something wrong, honey, they say, No I'm not wrong, I'm right, you're wrong (Rubin & Rhodes 2004, p. 166)

One interesting effect acculturation has on parent-child relationships is that mothers and fathers are not interchangeable informants about their children. A study found that mother-child agreement is weaker than father-child agreement. The mothers in this study did not know their children as well as the fathers when reporting about psychological well-being of their children to mental health workers. The researchers suggest that this is because of differing levels of acculturation allowing fathers (who are more acculturated) to better predict responses of their children and understand their children. Along with this, level of English language proficiency was also higher among the fathers, another indicator of greater acculturation (Rousseau & Drapeau 1998).

The psychosocial development of these individuals is also affected as they cope with changing family dynamics, life events in their new country and other ongoing stresses of acculturation (Kinzie, Boehnlein & Sack et al. 1998). As previously discussed, high rates of depression found among Cambodian children and adolescents have been found to correlate with recent life stressors, not experiences from the genocide. It is likely that recent life stressors have been influenced by issues with acculturation and changes in family dynamics. For example, in Cambodian families due to a child's greater acculturation, access to educational opportunities and language

proficiency, there can be a reversal in roles. The children become the cultural brokers; facilitate communication with the outside world and the result is the shift of authority to the children (Kinzie, Boehnlein & Sack et al. 1998). This can leave a great deal of emotional stress on the children due to the increased responsibility placed upon them. The children and adolescents are asked to take on additional roles within the family. Children are asked to care for the needs of the parent in relation to the outside mainstream culture and also to “single-handedly raise the family’s socioeconomic status through absolute commitment to school or work, regardless of his or her abilities (Rubin & Rhodes 2004, p. 175).” This is a lot of pressure for any individual let alone someone who is still a child and developing and discovering their identity. All of this pressure can lead to increased emotional distress, stress and even depression when the child is not able to live up to the expectations of their parents. These instances and pressure certainly add to the high depression rates among adolescents (Savin et al. 1996, Sack et al. 1995b).

The Effect of War Trauma and Resettlement Stress on Mental Health

The mental health of Cambodian refugee children has been affected in different ways by the stressors, events and traumas they have experienced. Experiences from life during the Khmer Rouge occupation, life in the refugee camps and the first years after resettlement are all associated with the high rates of Post Traumatic Stress Disorder found in these youth. During the five years of Khmer Rouge rule all Cambodians suffered from starvation, disease, and a loss of independence as daily life

was dictated by the Khmer Rouge. Children six and older were separated from their parents and forced to work in the rice fields and perform other hard labor such as building dams. Especially pertinent to mental health, everyone saw the atrocities committed against fellow Cambodians and many children saw their own family members brutally executed and tortured (Sack, W., Clarke, G., & Seeley, J. 1996). One child shared his coping method when seeing these executions:

I was in a temple where they killed three or four times a day. They told us to watch and not to show any emotion at all. They would kill us if we reacted... if we cried, or showed that we cared about the victims. They would kill you right away. So I had to shut it all off...I can shut off everything in my body, practically, physically. I saw them killing people right in front of me...The blood was there, but I didn't smell it. I made myself numb...The killing was unbearable. You go crazy if you smell the blood (Chan 2004 p.25-26).

The refugee children were also affected by the poor living conditions they were forced to endure, as illustrated by the following two narratives:

I lived in a children's camp...boys and girls lived together in an old, big, long house where they had beds made of bamboo slats, one stacked on top of the other like a triple bunk bed...I remember waking up every morning with my hair soaked...It was from the urine-the kids on top would urinate in their sleep and I would be completely soaked (Chan 2004 p. 24).

Being hungry, I stole a watermelon...But I was caught...The man who was in charge of the children's camp had this big rope and he tied me to a coconut tree. Under the coconut tree there were a lot of red ants that bite. He asked all the kids to come and watch-I was a bad example, he said, and if anyone else did what I did they would get the same punishment...He took honey and smeared it all over my legs, my arms, my face, so the ants would crawl up...they started biting. I cried and cried...I was left there the whole night... (Chan 2004 p.24).

Surviving the resettlement process, including life in the refugee camps, was also a traumatic experience. Resettlement stress encompasses the negative experiences associated with living in the refugee camps and being a new, non-English speaking immigrant in the United States. People began arriving and forming refugee camps in

Thailand as early as 1979 and some were still in these same camps in 1992 when forced repatriation to Cambodia began. There were over seven camps located on the Thai side of the Thailand-Cambodian border. While starvation was no longer common the camp populations were still chronically underfed. A 1987 UN survey found that approximately 30% of the population in Site II, the largest camp, were chronically malnourished. Food was provided by the UN in the form of weekly rations and water had to be trucked in daily from outside of the camp. Life was very unstable in the camps as health care, food provisions, jobs and even education were all dependent on foreign funding and volunteers (Savin et al. 1996). Life in the camps was dangerous. One adolescent described camp life as follows:

The word I would use to describe the camp is that it was like a prison. We were surrounded by barbed wire, two or three layers of barbed wire, and we were guarded by Thai soldiers. Anyone who dared to cross the barbed wire would be subject to death; they were killed...There were also a lot of robberies by Thai soldiers. There were a lot of rapes and other crimes committed against the refugees...At night the Thai guards knew who had daughters and possessions. They took the girls and robbed the refugees at night (Chan 2004 p. 53).

Refugees had to spend many years in the refugee camps, unable to return to Cambodia but not able to move to developed countries because of a lack of funds and sponsors. The lucky ones who did get to leave faced even more hardship as they had to adjust to a new culture and practices. Many Cambodian children were separated from family members during the resettlement process, never to hear of them again which has also caused a great deal of emotional distress.

All in all, those Cambodian children and adolescents who lived during the war and resettlement process have been impacted emotionally and mentally even decades later. It has been theorized, in regard to the Cambodian population, that a diagnosis of

PTSD must be precipitated by the experience of at least one major trauma event. It is not general feelings of displacement or loss that result in PTSD. For example, in one study participants diagnosed with PTSD reported specific traumas such as, “I saw a cadre kill a baby by throwing it in the air and catching it with his bayonet,” or “I was tied to a tree in the morning and was told I would have my head chopped off that evening (Sack W., Him, C., Dickason, D. 1999, p. 1175).” These are specific trauma events that the individual can remember years and decades later. Thus, the more war traumas reported by someone would result in a greater number of PTSD symptoms. In a study undertaken in 1990 at the Site II refugee camp, 182 Cambodian 12-13 year olds were asked to report the number of trauma events experienced. Nearly 20% saw a family member killed or seriously injured. 34% were close to death due to injury or illness. Nearly 100% experienced shelling or bombings. 102 of the children reported experiencing 2 or more trauma events and 17 of these children experienced 4-6 trauma events. It is important to note that this population of adolescents had similar characteristics to clinically referred adolescents in the United States (Mollica, R. et al. 1997).

Another interesting factor related to PTSD among Cambodian adolescents and children is that it can endure and persist over time. The only longitudinal study of the mental health of Cambodian adolescents was completed by Sack and colleagues. When this study began in 1983, 46 Khmer students located through a Portland Public High School were interviewed to determine their mental health diagnoses. These students were interviewed again in 1987, 1990 and 1996. In 1983 the students had not been in the U.S for more than three years, except for six students who had fled

Cambodia prior to the takeover of the Khmer Rouge (they were interviewed to provide a control group). In 1983, 50% of the subjects were diagnosed with PTSD. In 1987 that figure was reduced to 48%. The number of PTSD diagnoses decreased subsequently to 38% in 1990 and 35% in 1996 (12 years after the first interview). From this example we can see that war trauma stressors that occurred even 12-15 years earlier can still strongly impact current psychological wellbeing. Also, the absence of PTSD at one point in time doesn't guarantee continued absence. For example, 18% of the subjects didn't develop PTSD until five to eight years after the cessation of Pol Pot's rule in Cambodia. Three of the subjects did not report PTSD symptoms until the 1996 interview and one of those subjects was diagnosed for the first time. During the entire length of this long-term study 67% of the subjects were diagnosed with PTSD at some point during the 12-year period (Sack W., Him, C., Dickason, D. 1999).

The Effect of Current Stressors on the Mental Health of Khmer Children and Adolescents

In contrast to the experiences in Cambodia and the resettlement process, the effect of current stressors and life events in the United States have been found to correlate with major depression, not PTSD in Cambodian children and adolescents. Cambodian young people have had to deal with a variety of situations and events that have caused mental health consequences. As previously discussed, the impact of acculturation on the family unit has caused a great deal of stress and even caused traditional roles to switch as parents become reliant on their children to provide for them

financially and serve as an intermediary with mainstream society (Kinzie, Boehnlein & Sack et al. 1998). This has placed a great deal of stress and burden on the children. Intergenerational and intercultural conflict over appropriate attitude and actions has also led to distress among some young Cambodians. One young woman named Gom illustrates this

Gom is now a freshman in high school, and is very unhappy. A recent disagreement with [her] grandmother over using the phone and going out with friends has caused her to be profoundly sad. Her school grades have suffered and she, for the first time...is failing some classes. She spends much time in her room alone crying. She sleeps poorly, is tired, and has poor concentration and little energy (Kinzie, Boehnlein & Sack et al. 1998).

A second current stressor faced by this population includes community violence in the United States. In an exploratory study of the exposure of Cambodian adolescents to violence in Long Beach, California, it was found that half of the subjects survived violence directed at them and 2/3 witnessed violence. This study had 76 subjects and on average they were 8 years old upon their arrival in the United States. They were interviewed during middle school and high school. The main types of direct violence they experienced inside the United States were attacks (13%), threats (11%), and torture (4%). The main types of violence witnessed were attacks (41%), arrests (28%), threats (16%), and torture (11%). These children were on average less than 8 years old when living in Southeast Asia. The main types of direct violence they experienced while outside the United States were explosions (22%) and seeing dead bodies (15%). While this was an exploratory study, it was found that the number of violent events experienced in the United States had a strong impact on the mental health of these adolescents (Berthold 1999). Berthold found that the impact of violence in the United

States has affected mental health as negatively as violence experienced before arriving (Chan 2004).

One last current stressor that is pertinent to this population is poverty. As discussed in the first section, Cambodians in this country are characterized by high rates of poverty. 29.3% of Cambodian families live in poverty and the median income for a family of four is \$35,621.00 (We the People: Asians in the United States 2004). These amounts are especially low when the average number of individuals that live in a Cambodian household is taken into account, as previously discussed. These high rates of poverty and financial insecurity can greatly affect the mental health of Cambodian refugee children.

Current life stressors, such as the ones discussed above, can have a broad array of effects on children and adolescents, including separation anxiety, disruptive behaviors and depression. Life stressors and violent events in the U.S. have been shown to be definite risk factors for psychological conditions in general. Among Khmer adolescents and children depression is the mental health condition most commonly diagnosed that is associated with current life events (Clark, G. 1993).

The longitudinal study on Khmer refugee children and adolescents (that is described in the previous section) also included information on the progression of depression over time among this population. In 1983 (the first time the researchers saw the subjects) 48% were diagnosed with major depression. In 1986 this amount reduced to 41%. In 1990 depression diagnoses reduced even more to 7%. Then, in 1996, unlike PTSD diagnoses that continued to decrease, depression diagnoses increased to 14%. Unfortunately, no subsequent studies on this group of subjects have since been

published so we do not know if depression diagnoses continued to increase past 1996 in this group. Regardless, pertinent information can still be drawn from these results. Since depression rates increased between 1990 and 1996, well after the resettlement process was complete, the increase in diagnoses can be attributed to current stressors and not prior trauma. The trauma of these patients was related to current circumstances the subjects were confronting. In fact, two of those who were diagnosed with depression in 1996 were dealing with alcohol problems and another subject's depression was associated with an adjustment reaction (Sack W., Him, C., Dickason, D. 1999).

Comparison between PTSD and Depression Diagnoses in Khmer Children and Adolescents

While both depression and PTSD has been found to significantly affect Cambodian children and adolescents it is interesting to note the different courses the two conditions take over time. They are not co-morbid as previous studies have suggested. PTSD diagnoses and symptoms have been found to persist for long periods of time, while in comparison depression can change quite dramatically depending on the current life events the child or adolescent is experiencing (Clark 1993, Sack W., Him, C., Dickason, D. 1999).

A diagnosis of PTSD is highly dependent on what individuals recall from their traumatic experiences while living outside of the United States. As illustrated in the first section, the older an individual was during the Khmer Rouge rule and life in refugee

camp, the more likely they are to be diagnosed. Due to the effect age has on what one remembers those who were adolescents or adults are more likely to be diagnosed with PTSD. One study found that among adults 30%-50% were diagnosed with PTSD while among children the rate of diagnosis was only 20%-30% (Kinzie, Boehnlein & Sack 1998). These percentages illustrate the varied rates of diagnosis depending on a person's age. In relation to this, children of individuals who experienced numerous traumatic events are affected by their parents' PTSD diagnoses, as discussed previously. This same connection between age and rate of diagnosis is not found with depression. This is because depression is not as highly dependent on past experiences and traumas but instead what difficulties the individual is currently facing.

It is interesting that research completed with young Khmer refugees living in refugee camps have found similar results and support the findings of researchers working with this population in the United States. In one study, 99 Cambodian youth from the Site II refugee camp in Thailand completed similar diagnostic measures to those used in the U.S. to determine PTSD and depression prevalence rates. These children had not only survived Pol Pot's rule but also had been living in refugee camps for over a decade, which greatly impacted PTSD rates. 47.4% of the refugee camp youth had a lifetime prevalence rate of PTSD while 68.7% were diagnosed with depression at the time of the interviews. These rates, while much higher than those found among refugee children in the United States, still illustrate the impact resettlement and war trauma can have on PTSD diagnoses. The very high rates of depression are related to current life stressors for these youths. At the time they were interviewed and diagnosed, repatriation back to Cambodia was just beginning at Site II Refugee Camp.

The youth were facing many stresses related to their imminent return to Cambodia. They were worrying about finding employment, where they would be relocated, their safety on the return journey and the hope of finding lost family members. Rates of past depression diagnoses were also determined during interviews. 36.4% of the subjects had been previously diagnosed with depression, which illustrates that depression rates are not constant but change over time and are determined by specific life stressors that the individual may be facing (Savin et al. 1996).

The symptoms and severity of PTSD and depression can vary throughout an individual's lifetime and depends heavily on the life events and traumas they experience. In fact, PTSD symptoms can be reactivated when someone previously diagnosed with the disease experiences a secondary traumatization that is not related to the primary trauma that initiated the PTSD. One study reported that these refugees may experience a reactivation of PTSD symptoms when they experienced current stressors such as an assault or surgery (Kinzie 1988). For example when the images of the 9/11 terrorist attacks were broadcast on television many Cambodians had serious psychiatric reactions. In one study upon viewing these images Cambodian refugees reported feelings of fear (26% of participants) and uncertainty (23% of participants). While patients who were diagnosed with PTSD reacted more intensely to the images of 9/11, those whose primary diagnosis was depression also had a strong reaction. The reason that those with PTSD reacted more intensely was probably because the scenes of violence and death of 9/11 reminded them of the trauma events they experienced during the Pol Pot regime. Thankfully, all of the Cambodian participants in this study returned to their baseline clinical status approximately two to three months after viewing

the images of 9/11 on television (Kinzie et al. 2002).

Another interesting study found that Cambodians diagnosed with PTSD had more reaction to scenes of traumatic events (which were measured in terms of heart rate changes and behavior) than Vietnam veterans who also had PTSD. 68% of Cambodians with PTSD experienced an increase heart rate (characterized by more than 6 beats per minute above normal) when shown scenes of trauma and violence while only 19% of the Vietnam veterans has a similar response. For the Cambodians, the negative response to the scenes of trauma also persisted for weeks after as characterized by more intrusive and depressive thoughts, memories of the past and sadness. This indicates that the reactivation of symptoms for Cambodians may be more intense and pronounced than another highly traumatized group, Vietnam veterans (Kinzie et al. 1998).

Perhaps the most interesting dynamic of mental health issues among Cambodian youth is that their functional ability does not suffer, despite a mental health diagnosis (Mollica et al. 1997, Sack, Him & Dickason 1999, Rousseau & Drapeau 2004 & Chan 2004,). One study found that Cambodian youth who met the criteria for PTSD had a functional status that was as good as those that were not diagnosed. Also, there was no difference in GPA between students diagnosed with PTSD and those that were not. In this same study, the functional ability of parents with PTSD was also researched. In the parent group it was found that functional ability was affected with PTSD, unlike their children (Sack et al. 1995a).

Other researchers have also suggested that Cambodian youth display more resilience than their parents and are able to adapt and cope better in difficult situations.

This is partially due to the fact that young Cambodians have lower rates, later onset, and less persistence of PTSD symptoms than their parents overtime. This is a reality despite the fact that they too were exposed to violence and difficult situations overseas and in the United States. Many were also separated from parents during essential developmental stages in Cambodia, yet their functional ability has not been drastically impaired (Kinzie, Boehnlein & Sack et al. 1998). Even if Cambodian youth and young adults are able to function well in the United States despite severe mental health difficulties this does not mean that as a community, life has been easy in this country. According to the 2000 Census, only 9.2% of the population has earned at least an undergraduate college degree. This relates to the high dropout rates of Cambodian youth from high school. 29.3% of Cambodian also live in poverty (We the People: Asians in the United States 2004). This population is undoubtedly facing numerous difficulties living in the United States. The point is that their mental health issues are not adding a major burden to their ability to function and perform in today's society.

Conclusion

There is no question that Cambodian refugee children have been affected emotionally and mentally by their own traumatic experiences and those of their family members. Despite the many mental health concerns this population is facing the fact that they have been able to achieve so many accomplishments is extraordinary. As one researcher stated, "Given the horrific...trauma these subjects experienced...it is surprising that prevalence rates of PTSD were not 100%! (Sack, Him & Dickason 1999

p. 1178).” Cambodians in the United States are certainly a resilient group of individuals! As a whole, they have been able to overcome adversities that most Americans can never even fathom having to face. I for one have tremendous respect and regard for my future Cambodian family, despite the faults that some people may judge them for.

With the completion of my research I feel as if I am closer to my fiancé and his family. Even if I have not lived through the experiences and traumas they have at least I can empathize with their situation. I will never be able to share my research with my soon-to-be Cambodian family. They never talk about the many hardships they have faced. At least I can share what I have learned with any children we may have, so they will know their relatives better and empathize with what they had to endure so that future generations of the family could live in peace and safety.

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